Schedule of Benefits

Employer: **State of Maine**

ASA: 307297

Issue Date: October 23, 2013
Effective Date: July 1, 2013
Schedule: 1A
Booklet Base: 1

For: Aetna Choice POS II Plan (In State Plan)

Aetna Choice POS II Medical Plan

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Calendar Year Deductible*		
Individual Deductible*	$500	$2,500
Family Deductible*	$1,000	$5,000

*Unless otherwise indicated, any applicable **deductible** must be met before benefits are paid.

Plan Maximum Out of Pocket Limit includes plan **deductible**.

Plan Maximum Out of Pocket Limit excludes **precertification** penalties of $500 per type of covered expenses.

Individual Maximum Out of Pocket Limit:

- For **network** expenses: $2,000.
- For **out-of-network** expenses: $5,000.

Family Maximum Out of Pocket Limit:

- For **network** expenses: $4,000.
- For **out-of-network** expenses: $10,000.

Lifetime Maximum Benefit per person	Unlimited	Unlimited

Payment Percentage listed in the Schedule below reflects the Plan Payment Percentage. This is the amount the Plan pays. You are responsible to pay any deductibles and the remaining payment percentage. You are responsible for full payment of any non-covered expenses you incur.

All Covered Expenses Are Subject To The Calendar Year Deductible Unless Otherwise Noted In The Schedule Below.

Maximums for specific covered expenses, including visit, day and dollar maximums are combined maximums between network and out-of-network, unless specifically stated otherwise.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Preventive Care Benefits		
Routine Physical Exams ***Office Visits***	100% per visit No **copay** or Calendar Year **deductible** applies.	Not Covered
Covered Persons birth through age 18: Maximum Age & Visit Limits	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. *For details, contact your **physician** log onto the Aetna website www.aetna.com, or call the number on the back of your ID card.*	Not Covered
Covered Persons ages 18 and over Maximum Visits per 12 months	1 visit	Not Covered
Preventive Care Immunizations *Performed in a facility or **physician's** office*	100% per visit No **copay** or Calendar Year **deductible** applies.	Not Covered
Screening & Counseling Services - Obesity, Misuse of Alcohol and/or Drugs & Use of Tobacco Products	100% per visits No **copay** or Calendar Year **deductible** applies.	Not Covered
Obesity Maximum Visits per 12 months *(This maximum applies only to Covered Persons ages 22 & older.)*	26 visits *(however, of these only 10 visits will be allowed under the Plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)****	Not Covered
Note:** ***In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.		

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Misuse of Alcohol and/or Drugs Maximum Visits per 12 months	5 visits *	Not Covered
Note:** **In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.		
Use of Tobacco Products Maximum Visits per 12 months	8 visits *	Not Covered
Note:** **In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.		
Well Woman Preventive Visits ***Office Visits***	100% per visit No Calendar Year **deductible** applies.	Not Covered
Well Woman Preventive Visits Maximum Visits per Calendar Year	1 visit	Not Covered
Routine Gynecological Exam	100% per exam No Calendar Year **deductible** applies.	100% per exam No Calendar Year **deductible applies**
Hearing Exam	$25 exam **copay** then the plan pays 100% No Calendar Year **deductible** applies.	60% per exam after Calendar Year **deductible**
Hearing Supply Maximum per 36 month period children to age 19	100% after Calendar Year **deductible** up to $1,400 per ear	60% after Calendar Year **deductible** up to $1,400 per ear

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Routine Cancer Screenings		
Routine Cancer Screening Outpatient	100% per visit No Calendar Year **deductible** applies.	60% per visit after Calendar Year **deductible**
Maximums	Subject to any age and visit limits provided for in the current recommendations of the United States Preventive Services Task Force and comprehensive guidelines supported by the Health Resources and Services Administration. *For details, contact your **physician,** log onto the **Aetna** website www.aetna.com, or call the number on the back of your ID card.*	Subject to any age and visit limits provided for in the current recommendations of the United States Preventive Services Task Force and comprehensive guidelines supported by the Health Resources and Services Administration. *For details, contact your **physician,** log onto the **Aetna** website www.aetna.com, or call the number on the back of your ID card.*

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Routine Cancer Screenings		
Routine Mammography	100% per test No Calendar Year **deductible** applies.	100 % per test No Calendar Year **deductible** applies.
Prostate Specific Antigen Test	100% per test No Calendar Year **deductible** applies.	Not Covered
Maximum tests per Calendar Year	1 test	Not Covered
Routine Digital Rectal Exam	100% per test No Calendar Year **deductible** applies.	Not Covered
Maximum tests per Calendar Year	1 test	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Prenatal Care		
Office Visits	100% per visit No **copay** or Calendar Year **deductible** applies.	60% per visit after Calendar Year **deductible.**
Important Note: Refer to the Physician Services and Pregnancy Expenses sections of the Schedule of Benefits for more information on coverage levels for pregnancy expenses under this Plan, including other prenatal care, delivery and postnatal care office visits.		
Comprehensive Lactation Support and Counseling Services		
Lactation Counseling Services *Facility or Office Visits*	100% per visit No **copay** or Calendar Year **deductible** applies.	60% per visit after Calendar Year **deductible**
Lactation Counseling Services Maximum Visits either in a group or individual setting	6* visits per 12 months	6* visits per 12 months
***Important Note**: Visits in excess of the Lactation Counseling Services Maximum as shown above, are covered under the *Physician Services* office visit section of the *Schedule of Benefits*.		
Breast Pumps & Supplies	100% per item. No **copay** or Calendar Year **deductible** applies.	60% per item after Calendar Year **deductible**
Important Note: Refer to the *Comprehensive Lactation Support and Counseling Services* section of the Booklet for limitations on breast pumps and supplies.		
Family Planning Services		
Female Contraceptive Counseling Services -Office Visits.	100% per visit. No **copay** or Calendar Year **deductible** applies.	60% per visit after Calendar Year **deductible**
Contraceptive Counseling Services - Maximum Visits either in a group or individual setting	2* visits per 12 months	2* visits per 12 months
*Important Note: Visits in excess of the Contraceptive Counseling Services Maximum as shown above, are covered under the *Physician Services* office visit section of the *Schedule of Benefits*.		
Family Planning - Other		
Voluntary Termination of Pregnancy		
Preferred Providers Office Visit	100% per visit No **copay** or Calendar Year **deductible** applies.	60% per visit after Calendar Year **deductible**
Voluntary Sterilization for Males		
Preferred Providers Office Visit	100% per visit No **copay** or Calendar Year **deductible** applies.	60% per visit after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Family Planning - Other Voluntary Termination of Pregnancy		
All Other Network Providers **Office Visit**	$20 per visit **copay** No Calendar Year **deductible** applies.	60% per visit after Calendar Year **deductible**
Voluntary Sterilization for Males		
All Other Network Providers **Office Visit**	$20 per visit **copay** No Calendar Year **deductible** applies.	60% per visit after Calendar Year **deductible**

Family Planning - Other Voluntary Termination of Pregnancy		
Preferred Providers Outpatient	90% per visit after Calendar Year **deductible.**	60% per visit after Calendar Year **deductible.**
Voluntary Sterilization for Males		
Preferred Provider Outpatient	90% per visit after Calendar Year **deductible.**	60% per visit after Calendar Year **deductible.**

Family Planning - Other Voluntary Termination of Pregnancy		
All Other Network Providers **Outpatient**	80% per visit after Calendar Year **deductible.**	60% per visit after Calendar Year **deductible.**
Voluntary Sterilization for Males		
All Other Network Providers **Outpatient**	80% per visit after Calendar Year **deductible.**	60% per visit after Calendar Year **deductible.**

Family Planning - Female Voluntary Sterilization		
Inpatient	100% per visit No **copay** or Calendar Year **deductible** applies.	60% per visit after Calendar Year **deductible**
Outpatient	100% per visit No **copay** or Calendar Year **deductible** applies.	60% per visit after Calendar Year **deductible**

Family Planning - Female Contraceptives		
Female Contraceptives	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Vision Care		
Eye Examinations including refraction	100% per exam No Calendar Year **deductible** applies.	60% per exam after Calendar Year **deductible**
Maximum Benefit per Calendar Year	1 exam	1 exam

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Physician Services		
Office Visits to Primary Care Physician Office visits (non-surgical) to non-specialist		
Preferred Providers	100% per visit No Calendar Year **deductible** applies	60% per visit after Calendar Year **deductible**
All Other Network Providers	$20 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	60% per visit after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Alternatives to Physicians' Office Visits		
E-Visit Online Internet Consultation by a PCP		
Preferred Providers	100% per visit No **copay** or Calendar Year **deductible** applies	Not Covered
All Other Network Providers	$20 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	Not Covered
Specialist Office Visits	$25 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	60% per visit after Calendar Year **deductible**

Alternative to Specialist Office Visit		
E-visits Online Internet Consultation by a Specialist	$25 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	Not Covered
Physician Office Visits-Surgery		
Preferred Providers	100% per visit No Calendar Year **deductible** applies	60% per visit after Calendar Year **deductible**
All Other Network Providers	$20 per visit **copay** then the plan pays 100%	60% per visit after Calendar Year **deductible**
Specialist	$25 per visit **copay** then the plan pays 100%	60% per visit after Calendar Year **deductible**
Walk-In Clinics Non-Emergency Visit	$25 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	60% per visit after **deductible**

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Physician Services for Inpatient Facility and Hospital Visits		
Preferred Providers	90% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**
All Other Network Providers	80% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**
Administration of Anesthesia	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Allergy Testing and Treatment	100% per visit after applicable **copay** No Calendar Year **deductible** applies .	60% per visit after Calendar Year **deductible**

Allergy Injections	100% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**
Immunizations (when not part of the physical exam)	100% per visit No Calendar Year **deductible** apples	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Emergency Medical Services		
Hospital Emergency Facility and Physician	$150 **copay** per visit then the plan pays 100%	$150 **copay** per visit then the plan pays 100% See Important Note Below

Important Note: Please note that as these providers are not **network providers** and do not have a contract with **Aetna**, the provider may not accept payment of your cost share (your **deductible** and **payment percentage)**, as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this Plan. If the Emergency Room Facility or **physician** bills you for an amount above your cost share, you are not responsible for paying that amount. Please send us the bill at the address listed on the back of your member ID card and we will resolve any payment dispute with the provider over that amount. Make sure your member ID number is on the bill.

Non-Emergency Care in a Hospital Emergency Room	$150 **copay** per visit then the plan pays 100%	$150 **copay** per visit then the plan pays 100%

Important Notice:
A separate **hospital** emergency room **copay** applies for each visit to an emergency room for emergency care. If you are admitted to a **hospital** as an inpatient immediately following a visit to an emergency room, your **copay** is waived.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Urgent Care Services		
Urgent Medical Care *(at a non-hospital free standing facility)*	$25 **copay** per visit then the plan pays 100% No Calendar Year **deductible** applies.	60% per visit after Calendar Year **deductible**
Urgent Medical Care *(from other than a non-hospital free standing facility)*	Refer to *Emergency Medical Services* and *Physician Services* above.	Refer to *Emergency Medical Services* and *Physician Services* above.

Non-Urgent Use of Urgent Care Provider *(at an Emergency Room or a non-hospital free standing facility)*	$25 **copay** per visit then the plan pays 100% No Calendar Year **deductible** applies.	60% per visit after Calendar Year **deductible**

Important Notice:
A separate **urgent care copay** applies for each visit to an **urgent care provider** for **urgent care**.

Covered expenses that are applied to the **urgent care copay** cannot be applied to any other **copay** under your plan. Likewise, covered expenses that are applied to your plan's other **copays/deductibles** cannot be applied to the **urgent care copay**.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Outpatient Diagnostic and Preoperative Testing		
Complex Imaging Services		
Complex Imaging	$50 per visit **copay** then the plan pays No Calendar Year **deductible** applies	$50 per test deductible then the plan pays 100% No Calendar Year **deductible** applies
Diagnostic Laboratory Testing		
Diagnostic Laboratory Testing	90% per procedure after Calendar Year **deductible**	60% per procedure after Calendar Year **deductible**
Diagnostic X-Rays (except Complex Imaging Services)		
Diagnostic X-Rays	90% per procedure after Calendar Year **deductible**	60% per procedure after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Outpatient Surgery		
Outpatient Surgery		
Preferred Providers	90% per visit/surgical procedure after Calendar Year **deductible**	60% per visit/surgical procedure after Calendar Year **deductible**
Performed at an Ambulatory Surgery Center or Facility other than a Hospital Outpatient Facility	95% per visit after Calendar Year **deductible**	60% per visit/surgical procedure after Calendar Year **deductible**
All Other Network Providers	80% per visit after Calendar Year **deductible**	60% per visit /surgical procedure after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Inpatient Facility Expenses		
Birthing Center	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Hospital Facility Expenses Room and Board (excluding Maternity)		
Preferred Providers	90% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**
All Other Network Providers	80% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**
Preferred Providers (Other than Room and Board)	90% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**
All Other Network Providers (Other than Room and Board)	80% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**
Hospital Facility Expenses Room and Board - Maternity	100% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**
Other than Room and Board	100% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**
Skilled Nursing Inpatient Facility	100% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**
Maximum Days per Calendar Year	100 days	100 days

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Specialty Benefits		
Home Health Care (Outpatient)	100% per visit after the Calendar Year **deductible**	60% per visit after the Calendar Year **deductible**
Hospice Benefits		
Hospice Care - Facility Expenses (Room & Board)	100% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**
Hospice Care - Other Expenses during a stay	100% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**
Maximum Benefit per lifetime	Unlimited days	Unlimited days

Hospice Outpatient Visits	100% per visit after Calendar Year **deductible**	60% per visit after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Infertility Treatment		
Basic Infertility Expenses Coverage is for the diagnosis and treatment of the underlying medical condition causing the infertility only.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Comprehensive Infertility Expenses Expenses for Comprehensive Infertility services will not be used to satisfy the plan **Maximum Out-of Pocket Limit**.	80% per visit after Calendar Year **deductible**	Not Covered
Artificial Insemination Maximum Benefit	6 courses of treatment per lifetime	Not Covered
Ovulation Induction Maximum Benefit	6 courses of treatment per lifetime	Not Covered
Maximum per lifetime combined with (ART)*	$20,000	Not Covered
*The Comprehensive Infertility services maximum per lifetime amount shown above will not be used to satisfy the plan **Maximum Out-of-Pocket limit**.		
Advanced Reproductive Technology (ART) Expenses	80% per visit after Calendar Year **deductible**	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Inpatient Treatment of Mental Disorders		
Hospital Facility Expenses		
Room and Board	90% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**
Other than Room and Board	90% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**
Physician Services	90% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**

Inpatient Residential Treatment Facility Expenses	90% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**
Inpatient Residential Treatment Facility Expenses Physician Services	90% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**

Outpatient Treatment Of Mental Disorders		
Outpatient Services	$25 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies	60% per visit after the Calendar Year **deductible**

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Inpatient Treatment of Substance Abuse		
Hospital Facility Expenses		
Room and Board	90% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**
Other than Room and Board	90% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**
Physician Services	90% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Inpatient Residential Treatment Facility Expenses	90% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**
Inpatient Residential Treatment Facility Expenses Physician Services	90% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**

Outpatient Treatment of Substance Abuse		
Outpatient Treatment	$25 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies	60% per visit after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Obesity Treatment Surgical		
Inpatient Morbid Obesity Surgery (includes Surgical procedure and Acute Hospital Services) at Central Maine Medical Center, Eastern Maine Medical Center and Maine Medical Center	100% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**
All Other Network Providers	90% per admission after Calendar Year **deductible**	60% per admission after Calendar Year **deductible**
Outpatient Morbid Obesity Surgery at (Central Maine Medical Center, Eastern Maine Medical Center and Maine Medical Center)	100%% per service after Calendar Year **deducible**	60% per services after Calendar Year **deductible**
All Other Network Providers	90% per service after Calendar Year **deductible**	60% per services after Calendar Year **deductible**
Maximum Travel and Lodging Benefit Morbid Obesity Surgery (Inpatient and Outpatient) This maximum includes benefits provided or administered by Aetna or any affiliated company of Aetna	$10,000 per lifetime	$10,000 per lifetime

PLAN FEATURES	NETWORK (IOE Facility)	NETWORK (Non-IOE Facility)	OUT-OF-NETWORK
Transplant Services Facility and Non-Facility Expenses			
Transplant Facility Expenses Preferred Providers	90% per admission **copay** after Calendar Year **deductible**	60% per admission **deductible** after Calendar Year **deductible**	60% per admission **deductible** after Calendar Year **deductible**
Transplant Physician Services Preferred Providers (including office visits)	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided

PLAN FEATURES	NETWORK (IOE Facility)	NETWORK (Non-IOE Facility)	OUT-OF-NETWORK
Transplant Services Facility and Non-Facility Expenses			
Transplant Facility Expenses All Other Network Providers	80% per admission **copay** after Calendar Year **deductible**	60% per admission **deductible** after Calendar Year **deductible**	60% per admission **deductible** after Calendar Year **deductible**
Transplant Physician Services All Other Network Providers (including office visits)	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Other Covered Health Expenses		
Acupuncture	$25 per visit copay then the plan pays 80% No Calendar Year **deductible** applies	60% per visit after Calendar Year **deductible**
Ground, Air or Water Ambulance	100% after Calendar Year **deductible**	100% after **preferred** Calendar Year **deductible**
Diabetic Equipment, Supplies and Education	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Durable Medical and Surgical Equipment	100% per item after the Calendar Year **deductible**	60% per item after the Calendar Year **deductible**
Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Prosthetic Devices	100% per item after Calendar Year **deductible**	60% per item after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Outpatient Therapies		
Chemotherapy	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

Infusion Therapy	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

Radiation Therapy	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Short Term Outpatient Rehabilitation Therapies		
Outpatient Physical and Occupational Therapy only	$25 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies	60% per visit after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Short Term Outpatient Rehabilitation Therapies		
Speech Therapy only	$25 per visit **copay** then the plan pays 100% No Calendar year **deductible** applies	60% per visit after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Autism Spectrum Disorder		
	Cost sharing is based upon the type of service or supply provided and the place where the service or supply is rendered.	Cost sharing is based upon the type of service or supply provided and the place where the service or supply is rendered.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Spinal Manipulation		
	$25 per visit **copay** then the plan pays 100% No Calendar Year deductible applies.	60% per visit after Calendar Year **deductible**

Pharmacy Benefit

Copays/Deductibles

PER PRESCRIPTION COPAY/DEDUCTIBLE	NETWORK	OUT-OF-NETWORK
Preferred Generic Prescription Drugs		
For each 30 day supply (retail)	$10	$10
For more than a 30 day supply but less than a 91 day supply (mail order)	$15	Not Applicable
Preferred Brand-Name Prescription Drugs		
For each 30 day supply (retail)	$30	$30
For more than a 30 day supply but less than a 91 day supply (mail order)	$45	Not Applicable
Non-Preferred Generic Prescription Drugs		
For each 30 day supply (retail)	$10	$10
For more than a 30 day supply but less than a 91 day supply (mail order)	$15	Not Applicable
Non-Preferred Brand-Name Prescription Drugs		
For each 30 day supply (retail)	$45	$45
For more than a 30 day supply but less than a 91 day supply (mail order)	$70	Not Applicable
Infertility/ Erectile Dysfunction Prescription Drugs		
For each 30 day supply (retail)	$50	$50
For more than a 30 day supply but less than a 91 day supply (mail order)	$75	Not Applicable

If a **prescriber** prescribes a covered **brand-name prescription drug** where a **generic prescription drug** equivalent is available and specifies "Dispense As Written" (DAW), you will pay the cost sharing for the **brand-name prescription drug**. If you request a covered brand-name **prescription drug** where a **generic prescription drug** equivalent is available you will be responsible for the cost difference between the **brand-name prescription drug** and the **generic prescription drug** equivalent, plus the applicable cost sharing.

Coinsurance

	NETWORK	OUT-OF-NETWORK
Prescription Drug Plan Coinsurance	100% of the **negotiated charge**	100% of the **recognized charge**

The **prescription drug** plan **coinsurance** is the percentage of **prescription drug covered expenses** that the plan pays after any applicable **deductibles** and **copays** have been met.

Precertification for certain **prescription drugs** is required. If **precertification** is not obtained, the **prescription drug** will not be covered.

Expense Provisions

The following provisions apply to your health expense plan.
This section describes cost sharing features, benefit maximums and other important provisions that apply to your Plan. The specific cost sharing features and the applicable dollar amounts or benefit percentages are contained in the attached health expense sections of this *Schedule of Benefits*.

This *Schedule of Benefits* replaces any *Schedule of Benefits* previously in effect under your plan of health benefits.

KEEP THIS SCHEDULE OF BENEFITS WITH YOUR BOOKLET.

Deductible Provisions

You and each of your covered dependents have separate Calendar Year **deductibles**. Each of you must meet your **deductible** separately and they cannot be combined. This Plan has individual and family Calendar Year **deductibles**.

Network Provider Calendar Year **Deductible**

Individual
This is the amount of **covered expenses** that you and each of your covered dependents incur each Calendar Year from a **network provider** for which no benefits will be paid. This individual Calendar Year **deductible** applies separately to you and each of your covered dependents. After **covered expenses** reach this individual Calendar Year **deductible**, this Plan will begin to pay benefits for **covered expenses** that you incur from a **network provider** for the rest of the Calendar Year.

Family Deductible Limit
When you and each of your covered dependents incur **covered expenses** that apply towards the individual Calendar Year **deductibles,** these expenses will also count toward a family **deductible** limit.

To satisfy this family **deductible** limit for the rest of the Calendar Year, the following must happen:

> The combined **covered expenses** that you and each of your covered dependents incur towards the individual Calendar Year **deductibles** must reach this family **deductible** limit in a Calendar Year.

When this occurs in a Calendar Year, the individual Calendar Year **deductibles** for you and your covered dependents will be considered to be met for the rest of the Calendar Year.

Out-of-Network Provider Calendar Year **Deductible**

Individual
This is the amount of **covered expenses** that you and each of your covered dependents incur each Calendar Year from an **out-of-network provider** for which no benefits will be paid. This individual Calendar Year **deductible** applies separately to you and each of your covered dependents. After **covered expenses** reach this individual Calendar Year **deductible**; this Plan will begin to pay benefits for **covered expenses** that you incur from an **out-of-network provider** for the rest of the Calendar Year.

Family Deductible Limit
When you and each of your covered dependents incur **covered expenses** that apply towards the individual Calendar Year **deductibles,** these expenses will also count toward a family **deductible** limit.

To satisfy this family **deductible** limit for the rest of the Calendar Year, the following must happen:

> The combined **covered expenses** that you and each of your covered dependents incur towards the individual Calendar Year **deductibles** must reach this family **deductible** limit in a Calendar Year.

When this occurs in a Calendar Year, the individual Calendar Year **deductibles** for you and your covered dependents will be considered to be met for the rest of the Calendar Year.

Deductible Carryover
Under this feature, any **covered expenses** that you incur in the last three months of a Calendar Year that apply toward that year's Calendar Year **deductibles** for **network providers** or **out-of-network** providers will also count toward the following year's **network providers** or **out-of-network** providers **deductibles**.

Deductible Waiver Provision for Preventive Prescription Drug Expenses
No **deductible** will apply to preventive covered **prescription drug** expenses for those **prescription drugs** used to treat the prevention of conditions relating to:

- Hypertension;
- Heart disease;
- Diabetic complications;
- Asthmatic episodes;
- Conditions resulting from osteoporosis;
- Stroke;
- Various pediatric conditions, such as vitamins and fluoride deficiency, and maternal and fetal problems during pregnancy

The preventive **prescription drug** list is available from your employer in printed form. Member Services can answer any questions you have about this preventive **prescription drug** list.

Copayments and Benefit Deductible Provisions

Copayment, Copay
This is a specified dollar amount or percentage of the **negotiated charge** required to be paid by you at the time you receive a covered service from a **network provider**. It represents a portion of the applicable expense.

Payment Provisions

Payment Percentage

This is the percentage of your **covered expenses** that the plan pays and the percentage of **covered expenses** that you pay. The percentage that the plan pays is referred to as the "Plan Payment Percentage". Once applicable **deductibles** have been met, your plan will pay a percentage of the **covered expenses**, and you will be responsible for the rest of the costs. The payment percentage may vary by the type of expense. Refer to your *Schedule of Benefits* for payment percentage amounts for each covered benefit.

Maximum Out-of Pocket Limit

The **Maximum Out-of Pocket Limit** is the maximum amount you are responsible to pay for **covered expenses** during the Calendar Year. This Plan has an individual **Maximum Out-of Pocket Limit**. As to the individual **Maximum Out-of Pocket Limit**, each of you must meet your **Maximum Out-of Pocket Limit** separately and they cannot be combined and applied towards one limit.

Certain **covered expenses** do not apply toward the **Maximum Out-of Pocket Limit**. See list below.

Network Provider Maximum Out-of Pocket Limit

Individual

Once the amount of eligible **network provider** expenses you or your covered dependents have paid during the Calendar Year meets the individual **Maximum Out-of Pocket Limit**, this Plan will pay 100% of such **covered expenses** that apply toward the limit for the remainder of the Calendar Year for that person.

Family Maximum Out-of Pocket Limit

When you and each of your covered dependents incur **covered expenses** that apply towards the individual Calendar Year **network provider Maximum Out-of Pocket Limit,** these expenses will also count toward a family **network provider Maximum Out-of Pocket Limit**.

To satisfy this family **network provider Maximum Out-of Pocket Limit** for the rest of the Calendar Year, the following must happen:

> The family **Maximum Out-of Pocket Limit** is a cumulative **Maximum Out-of Pocket Limit** for all family members. The family **network provider Maximum Out-of Pocket Limit** can be met by a combination of family members with no single individual within the family contributing more than the individual **network provider Maximum Out-of Pocket Limit** amount in a Calendar Year.

Out-of Network Provider Maximum Out-of Pocket Limit

Individual

Once the amount of eligible **out-of-network provider** expenses you or your covered dependents have paid during the Calendar Year meets the individual **Maximum Out-of Pocket Limit**, this Plan will pay 100% of such **covered expenses** that apply toward the limit for the remainder of the Calendar Year for that person.

Family Maximum Out-of Pocket Limit

When you and each of your covered dependents incur **covered expenses** that apply towards the individual Calendar Year **out-of-network provider Maximum Out-of Pocket Limit,** these expenses will also count toward a family **out-of-network provider Maximum Out-of Pocket Limit**.

To satisfy this family **out-of-network provider Maximum Out-of Pocket Limit** for the rest of the Calendar Year, the following must happen:

> The family **Maximum Out-of Pocket Limit** is a cumulative **Maximum Out-of Pocket Limit** for all family members. The family **out-of-network provider Maximum Out-of Pocket Limit** can be met by a combination of family members with no single individual within the family contributing more than the individual **out-of-network provider Maximum Out-of Pocket Limit** amount in a Calendar Year.

The **Maximum Out-of Pocket Limit** applies to both network and out -of-network benefits. **Covered expenses** applied to the out-of-network **Maximum Out-of Pocket Limit** will be applied to satisfy the in-network **Maximum Out-of Pocket Limit** and **covered expenses** applied to the in-network **Maximum Out-of Pocket Limit** will be applied to satisfy the out-of-network **Maximum Out-of Pocket Limit**.

Expenses That Do Not Apply to Your Out-of-Pocket Limit
Certain covered expenses do not apply toward your plan **out-of-pocket** limit. These include:

- Charges over the **recognized charge** for **out-of-network providers** only;
- Expenses to which a copayment is applied;
- Expenses incurred for outpatient **prescription drugs**;
- Non-covered expenses;
- Expenses incurred for non-urgent use of an **urgent care provider**; and
- Expenses that are not paid, or **precertification** benefit reductions because a required **precertification** for the service(s) or supply was not obtained from **Aetna**.

Precertification Benefit Reduction

The Booklet contains a complete description of the **precertification** program. Refer to the "Understanding Precertification" section for a list of services and supplies that require **precertification**.

Failure to precertify your **covered expenses** for **out-of-network providers** when required will result in a benefits reduction as follows:

- A $500 benefit reduction will be applied separately to each type of expense.

General

This Schedule of Benefits replaces any similar Schedule of Benefits previously in effect under your plan of benefits. Requests for coverage other than that to which you are entitled in accordance with this Schedule of Benefits cannot be accepted. This Schedule is part of your Booklet and should be kept with your Booklet.